Physician Responsibility and Patient Freedom

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WANDERING THROUGH the history of medicine one can find no period comparable to the present in which there has been so much concern about quality of life. Perhaps knowledge and resources were so limited in times past that physicians could do little more than try to grapple (often without coming to grips) with life and death situations. The only variable was the personality of the individual physician—a force not to be underestimated—since often it represented the only tool available.

But we have transcended this era. With our modern engines of survival we have forced the enemy death onto new unfamiliar terrain. Definitions of life and death are obscured. Diseases with predictable outcomes in the past must be reevaluated, for each day brings some new physiologic revelation. And this is prelude to the salvage of patients who would have died a few years back.

In this new environment the physician has changed. No longer is he a fusty mystical character who charmed and cajoled and scolded and prayed while dispensing his dreadful draughts and preposterous potions. He knew of his diagnostic and therapeutic impotence. It was a time of frustration for the conscientious; a heyday for charlatans.

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It has only been a few generations since physicians have been given power over disease. And with this has come a change in philosophy. We have become a profession of optimists, and some among us feel there will be no limit to our ultimate power to heal. Most of us have become so smitten with this new capability that we have become zealots, missionaries, crusaders in the cause of health. I fear the pendulum has swung a bit far.

By the very nature of our calling, physicians are adversaries of the enemy death and its cohort disability. Our literature reflects this attitude. Until recently success in medicine was measured by objective remission or temporal survival, with scant attention to quality of life. It was inconceivable to most of us that anyone could place health and survival at a lower level of priority than security, money, pleasure, work or any other consideration. Yet, there always have been some persons who did just that.

So where does the physician draw the line? Where does *physician responsibility* end and *patient freedom* begin? What do you do with a patient who suffers the hellfire of recurring pancreatitis, yet continues to drink alcohol; a patient with chronic obstructive airways disease with recurring bouts of bronchitis, who continues to smoke cigarettes; a businessman with two previous myocardial infarctions, who continues to eat to excess, refuses to exercise and maintains a breakneck pace in his business?

Carry it one step further. How do you regard any motorist who refuses to wear a seatbelt, a motorcyclist who scorns a helmet or anyone who voluntarily jumps out of airplanes?

How about a patient with metastatic disease of the colon who makes the decision against chemotherapy? She prefers morphine—promethazine and a short life to more prolonged survival with hair loss, recurring oral ulcers, and the conse-

Refer to: Moser RH: Physician responsibility and patient freedom, *In* Medicine and the quality of life—A forum. West J Med 125:10-12, Jul 1976

quences of pancytopenia and compromised immunity.

Who is right? Should a physician refuse to take care of a patient who has a serious chronic illness that is amenable to palliation, yet who ignores advice which is predicated on years of clinical wisdom? How does one tread that line between professional obligation to the *patient* and respect for the integrity of a free, properly informed *human being?*

Too much permissiveness and we abdicate our classical role as a physician-parent, we leave many less sophisticated patients lost and bewildered. To many such persons the physician is still all-powerful—his word is gospel and his orders are to be followed absolutely. Such patients are childlike in their faith. They assume a fundamental integrity, a sense of responsibility on the part of a physician that is preeminent above all other considerations. They do not challenge; they do not question. They are rare.

Others accept the physician as a dedicated—but fallible—human being. They expect a reasonable explanation of diagnostic procedures and therapeutic interventions, and a reasonable prognostic guess. They will cooperate as intelligent, informed members of the therapeutic team. But they reserve the right to final judgment about selecting the quality of their life.

I believe we must not capitulate and yield to the caprice and whim of a frightened or panicky or ill-informed patient. Yet I do not believe we can impose our "crusade of good health" upon the patient. I sometimes have the vision of medicine wielding a giant mold—impressing it irrevocably upon patients—and attempting to stamp each patient according to our fixed concept of compliance to the "rules of good health." This approach fails to account for the enormous variation in individual goals, life-styles, desires, ambitions, self images.

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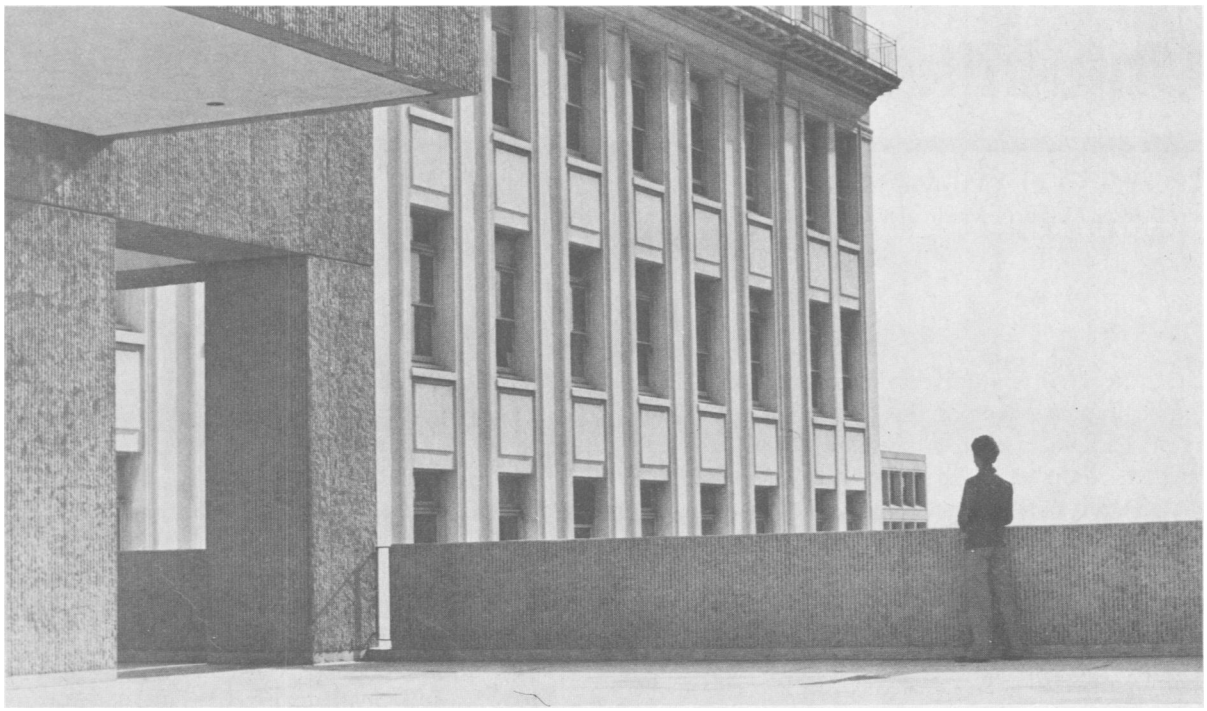
There is a need for appropriate salesmanship as we attempt to convince a patient to accept a diagnostic procedure or a therapeutic manipulation that we are convinced is in his best interest. But in the same moment we must realize that there are still some patients who will disagree and make different decisions about what takes priority in their lives. They are listening to that different drummer, and one cannot command or legislate good health habits. Such things are alien to the spirit of free men.

We speak a great deal about bringing patients



into the therapeutic team—to ensure compliance with therapy. This is a new concept. In the past the almighty physician would make the diagnostic pronouncement and scribble an illegible Latinoid prescription, and the patient would depart—meekly accepting the talisman without question. The physician would take comfort in the delusion that since the patient "made the effort to come to see me, he will abide by my judgment and recommendations." It was considered as an article of medical faith. In most instances little effort was made to ensure comprehension and faithfulness in following instructions. It was rare for an explanation of the goals and hazards of therapy to accompany the magic slip of paper. Most often the transaction was an arbitrary monologue. And often failure of the patient to respond was related to the "inexorable course of the illness," with nary a thought that the patient might not even have purchased the medication.

Successful management of chronic diseases demands patient cooperation. Most patients are eager to learn about their disease, and many become intelligent partners in management. We have learned this lesson from patients with diabetes mellitus who can be taught to manipulate their insulin and diet on the basis of urine glucose analysis and early minor symptoms. We have learned from hypertensive patients who take blood pressure readings at home and are able to adjust their drug therapy accordingly. We have learned from patients with coronary heart disease who can be taught to exercise to specific limits of heart rate and anginal discomfort. All are examples of team management, and there are dozens of others.

The day has passed when we can declaim with thunder from Olympus, "I *know* what is best for you." On what basis do we judge a patient who opts for a short, pain-free, joyful (for him) life—rather than a longer road of discipline and discomfort. (I realize the options are rarely black or white, but I must confess I am not sure of my own reaction were I given the choice of an additional year or two of life with palliative cancer chemotherapy and its sequelae, or a trip to see the Taj Mahal by moonlight and the wonders of the Nile and other untasted delights, while aided by morphia.)

Certainly full disclosure measured to the intellectual and emotional capacity of the patient, with forthright recommendations—is the obligation of every physician. But we must respect the judgment of a patient who still elects to place priority on something other than health or longevity or even freedom from discomfort. I feel this philosophy represents a new plane in the evolution of the healing arts.

Unfulfilled Expectations

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GOOD HEALTH is a universal concern that is basic to the improvement of the quality of life. However, medicine's narrow popular definition which is often confined to the treatment of diseases and the delivery of health services has distorted its meaning both for the doctor himself as well as his patients. Such limited application has tended to denigrate the role of the doctor in improving the quality of life. The doctor finds himself in the contradictory position of probably having contributed more, as well as failed more, than almost any other professional to improve the quality of life of his fellow human beings. In my activities to increase the pool of persons who are being educated as health professionals, I am usually looking at the essential contributions of health professionals—especially doctors. Conversely, my concern for the recipients of health services via our health centers brings me face to

Refer to: Elam LC: Unfulfilled expectations, *In* Medicine and the quality of life—A forum. West J Med 125:12-14, Jul 1976